Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INNOVA HOSPITAL SAN ANTONIO
4243 E SOUTHCROSS BLVD
SAN ANTONIO TX 78222-3727

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-3734-01

MFDR Date Received
April 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital believes the insurance carrier failed to properly reimburse the hospital fees leaving the Hospital no choice but to seek medical fee dispute resolution."

Amount in Dispute: $14,087.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier paid $152.49 of the bill for $14,239.70. The rest of the bill was not paid for improper coding. A provider must make a timely and valid request for reconsideration before requesting medical dispute resolution… there is no evidence of that and carrier did not receive such a request."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2009	Outpatient Hospital Services	$14,087.21	$2,655.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 95 – Plan procedures not followed.

- 859 – PLEASE PROVIDE A VALID NDC, CPT, HCPCS CODE, CHARGEMASTER CODE, AND/OR QUANTITY, ALONG WITH AN INVOICE IF APPLICABLE FOR APPROPRIATE REIMBURSEMENT. $0.00
- W1 – Workers Compensation State Fee Schedule Adjustment
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.

Issues

1. Did the provider seek reconsideration from the insurance carrier prior to requesting medical fee dispute resolution?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.250(h), "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General)." The respondent asserts that "A provider must make a timely and valid request for reconsideration before requesting medical dispute resolution… there is no evidence of that and carrier did not receive such a request." Review of the submitted documentation finds a letter from Bunch & Associates, Inc. dated January 12, 2010, which states "We recently received your appeal letter regarding the above reference workers' compensation bill . . . We have compared your billing with the audit report prepared. Based upon the information we have received, we believe that our audit is correct." The requestor has supported that the insurance carrier took final action on the medical bill after reconsideration. The Division concludes that the requestor has met the requirements of §133.250.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code J1810 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
   - Procedure code J3302 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code A4615 has a status indicator of Y, which denotes non-Implantable durable medical equipment not paid under OPPS. Reimbursement is not recommended.
   - Procedure code A4209 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
   - Procedure code A4930 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $9.24. 125% of this amount is $11.55. The recommended payment is $11.55.
- Procedure code 82962 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $3.42. This amount multiplied by 2 units is $6.84. 125% of this amount is $8.55. The recommended payment is $8.55.
- Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.82. This amount multiplied by the annual wage index for this facility of 0.8917 yields an adjusted labor-related amount of $23.92. The non-labor related portion is 40% of the APC rate or $17.88. The sum of the labor and non-labor related amounts is $41.80. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.308. This ratio multiplied by the billed charge of $250.00 yields a cost of $77.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $41.80 divided by the sum of all APC payments is 63.14%. The sum of all packaged costs is $4,198.88. The allocated portion of packaged costs is $2,651.26. This amount added to the service cost yields a total cost of $2,728.26. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,655.11. 50% of this amount is $1,327.56. The total APC payment for this service, including outliers, is $1,369.36. This amount multiplied by 200% yields a MAR of $2,738.71.
- Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment is included in package if billed on same date as services with status indicator S, T, V, or X; otherwise paid separately. Review of the medical bill finds that procedure cod 71020 with a status indicator of X was performed on the same date of service. Payment for procedure code 76000 is therefore a packaged service with no separate APC payment. Separate payment is not recommended.
- Procedure code 09125 is not a valid procedure code. This service was billed under revenue code 370 which represents anesthesia services that are typically packaged services with no separate APC payment. Reimbursement is not supported.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $26.09. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.65. This amount multiplied by the annual wage index for this facility of 0.8917 yields an adjusted labor-related amount of $13.96. The non-labor related portion is 40% of the APC rate or $10.44. The sum of the labor and non-labor related amounts is $24.40. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $24.40. This amount multiplied by 200% yields a MAR of $48.80.

5. The total recommended payment for the services in dispute is $2,807.61. This amount less the amount previously paid by the insurance carrier of $152.49 leaves an amount due to the requestor of $2,655.12.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,655.12.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to

additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,655.12, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	August 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.